APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
PROVIDER SUPPORT OFFICE

REQUEST TYPE

Effective Date					
_____/_____/_____	☐ Add New User	☐ Update Existing User	☐ Add Reporting Unit ☐ Delete Reporting Unit ☐ Name Change	☐ Add Role ☐ Delete Role Unit ☐ Termination	☐ Add User Access ☐ Delete User Access

EMPLOYEE STATUS

☐ DMH Permanent ☐ DMH Temporary ☐ FFS IP ☐ FFS OP ☐ MHSA ☐ NGA ☐ DHS

APPLICATION INFORMATION

User/Logon ID	Last Name	First Name	MI	Last 4 Digits of SSN

Date of Birth MM/DD	Sex Code	Ethnicity Code	Handicap Code	Language Code	Name of Facility/Bureau/FFS Network Provider/Pharmacy

Program Name/Unit	Address	Suite/Floor

City	State	Zip Code	Phone Number	E-Mail Address

ROLE(S)

Provider using Web Services? ☐ Yes ☐ No

SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

DMH Provider No(s)

NGA Legal Entity No.

DHS Provider No(s)

FFS Provider No.

SELECT APPLICATION ACCESS

☐ Integrated System ☐ STAR ☐ Provider Connect* ☐ PRM* Other (please specify _____)

The following forms must be signed and sent with this document:

☐ COLA Agreement for Acceptable Use ☐ Oath of Confidentiality ☐ E-Signature Agreement

SIGNATURES

Applicant Name	Signature	Date Completed

Contact (Print Name)	Phone Number	Date Completed

Program Head/Authorized Designee (Print Name)	Signature	Date Completed

FOR PSO USE ONLY

User ID	HEAT Call Ticket	Date Received

Processed By	Remarks	Date Completed

***Provider Connect or PRM User Access?**
Scan and Email forms to:
DMHPSO@dmh.lacounty.gov

User Access for all other Applications?
Mail all forms to:
DMH PSO Systems Access Unit
695 S. Vermont Avenue
Los Angeles, CA 90005